Courage Kenny Rehabilitation Institute
Patient Intake Questionnaire

Please answer the following questions to the best of your ability.

What problem brings you here?

When did this problem start?

How has this problem affected your ability to participate in activities, such as work, school, social or church activities, parenting, caregiving, volunteering, etc.?

Do you have pain or difficulty with any of the following activities? (Check all that apply.)
☐ None ☐ Bathing/grooming ☐ Dressing ☐ Household chores ☐ Stairs
☐ Driving ☐ Yard work ☐ Cooking ☐ Other (please specify) _____

Whom have you seen (or are you seeing) for this problem?
☐ Medical doctor ☐ Physician assistant ☐ Speech/language pathologist ☐ Chiropractor
☐ Physical therapist ☐ Occupational therapist ☐ Psychiatrist/psychologist ☐ Nurse practitioner
☐ Worker's comp ☐ Other _____

Are you currently residing in a skilled nursing facility? ☐ Yes ☐ No
If yes, your insurance may not cover therapy services provided in this department.

Are you currently receiving home care services (e.g. nursing, infusion or therapy)? ☐ Yes ☐ No
If yes, your insurance may not cover therapy services provided in this department.

What is your goal for therapy?

Pain Description: Are you experiencing pain? ☐ Yes ☐ No If yes, where? _____
If yes, please circle the number that best describes your level of pain:
No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*
Describe your pain (check all that apply): ☐ No pain ☐ Shooting ☐ Aching ☐ Throbbing ☐ Dull ☐ Sharp ☐ Burning

Pain Goal: What is an acceptable level of pain (on a scale of 0–10 with "0" meaning no pain and "10" meaning unbearable pain): _____
What helps your pain? _____

Please list any restrictions your doctor(s) has/have given you:

How would you describe your general health? ☐ Good ☐ Fair ☐ Poor

Have you been hospitalized in the last year? ☐ Yes ☐ No If yes, what for _____

If you are a female, are you or could you be pregnant? ☐ Yes ☐ No

Which tests have you had for this problem? ☐ None ☐ X-ray ☐ MRI ☐ CT Scan
☐ Swallow Study ☐ Other (please specify) _____

Have you had recent injections? ☐ Yes ☐ No If yes, which body part? _____
When? _____

Do you have any cultural, religious, or spiritual beliefs or practices that you would like us to know about?
☐ Yes ☐ No If yes, please specify: _____

How do you learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures

Do you have any learning difficulties or barriers? ☐ Yes ☐ No If yes, please specify: _____

PATIENT LABEL

Patient Name: _____

DOB: _____

MRN: _____

Do you receive your medical care from an Allina Health facility?

☐ Yes (skip to page 3) ☐ No (complete page 2 and 3)

Past/Present Conditions

☐ Heart disease	☐ Headaches/migraines	☐ Asthma
☐ Stroke	☐ Bowel problems	☐ Osteoporosis
☐ High blood pressure	☐ Bladder problems	☐ Smoker
☐ Lung disease	☐ Seizures	☐ Pacemaker/other implantable
☐ Cancer	☐ Bleeding disorder	☐ Mental illness
☐ Thyroid disorder	☐ Kidney disease	☐ Other (please specify): _____
☐ Arthritis	☐ Diabetes	_____

Difficulties/Equipment

☐ Visual difficulties	☐ Communication device	☐ Glasses/contact lenses
☐ Hearing difficulties	☐ Memory aid	☐ Cane
☐ Speech/language problem	☐ Hearing aid	☐ Crutches
☐ Voice problem	☐ Splints	☐ Walker
☐ Attention problem	☐ Orthotics	☐ Wheelchair
☐ Memory problem	☐ Prosthesis	☐ Other (please specify): _____
	☐ Swallowing difficulty	_____

Allergies* Do you have allergies to medicines, latex, foods or anything else? ☐ Yes ☐ No If yes, please list below:

Allergy	Reaction

Medicines* Are you currently taking any medicines (prescription, over-the-counter, vitamins, supplements or herbal products)? ☐ Yes ☐ No If yes, please list below:

Medicine	Dose	Taken For

Surgeries/Procedures* Have you had any previous surgeries? ☐ Yes ☐ No If yes, please list below:

Surgery	When

PATIENT LABEL

Patient Name: _____

DOB: _____

MRN: _____

Concerns (please check all that apply)	
☐ I have fallen in the last year. ☐ I am afraid of falling. ☐ I have nutritional concerns. ☐ I have had unexplained weight change (more than a 10 pound loss or gain). ☐ I have difficulties with swallowing.	☐ I have difficulty doing daily activities at home. ☐ I have concerns about my health. ☐ I feel depressed. ☐ I have severe anxiety that affects my quality of life. ☐ I am concerned for my safety. ☐ Other (please specify) _____

Are you interested in receiving information about:

☐ Comprehensive driving program ☐ Support groups/counseling services

☐ Recreational services/adaptive sports ☐ Social services

☐ Vocational services

Patient Signature: **Date:**

Parent/Guardian Signature: **Date:**

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Patient Concerns	Patient Encouraged to Follow up with PCP	Community Resource Info Offered/Provided	Additional Follow Up Beyond Treatment Not Necessary
Recent falls/fear of fall	☐	☐	☐
Nutritional concerns	☐	☐	☐
Significant unexplained weight loss	☐	☐	☐
Swallowing concerns	☐	☐	☐
Difficulty doing activities of daily living	☐	☐	☐
Health Concerns	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Safety	☐	☐	☐
Other	☐	☐	☐

☐ **Patient demonstrates a willingness to learn** ☐ **Patient is willing to participate in plan of care**

Therapist Signature/Credentials: **Date:** **Time:**

Therapist Signature/Credentials: **Date:** **Time:**

Therapist Signature/Credentials: **Date:** **Time:**

PATIENT LABEL

Patient Name: _____

DOB: _____

MRN: _____